Request for Prior Authorization Number Clients Enrolled for MCM or PWI prior to September 1, 2003 and Transfer of Current Prior Authorization Numbers (PAN)

(for clients to be enrolled on or after September 1, 2003 CPW-01 must be used)
(this form not for use after December 31, 2003)

Last Name: _____ First Name: _____

Medicaid Number: Date of Birth:

Part 1----Case Information	
Do you expect the case to remain open after September 1, 2003?	☐ Yes ☐ No, if no, there is no need to submit this form for PAN
Date case opened:	Date of comprehensive visit (MCM) or date of service plan (PWI):

Part 2----Health Condition/Health Risk (0 through age 20 and pregnant women) or Psychosocial Risk/Condition (pregnant women only) use specific risk, condition or symptoms that describe the health condition if diagnosis not confirmed	
Primary:	
Secondary:	

Part 3----Need for case management
Description of how health condition/health risk sets client apart from healthy same age peers and limits their level of function. For pregnant women indicate how risk condition impacts pregnancy and expected date of delivery.
Identified complicating psychosocial factors that have an impact on client's condition
Specific need for case management including unmet needs and need for referrals

Part 4----service with current authorization			
Has prior authorization been requested and approved for this client? ☐ Yes ☐ No if yes move to next column if no move to section 5	If yes, PAN reference number from CPW-06	**Services**	
		number prior authorized	**number remaining in current authorization**
	Expiration date of PAN from CPW-06	comp_____ follow-up visits face to face _____ telephone _____	comp_____ follow-up visits face to face _____ telephone _____

Last Name: _____ First Name: _____

Medicaid Number: Date of Birth:

Part 5---service without current prior authorization
How many follow-up/monitoring visits have been conducted since opening the case? _____
Number of follow-up services expected to be needed prior to case closure _____ Number of face-to-face follow-up visits expected: _____ Number of telephone follow-up visits expected: _____

Case manager signature Date

Case manager name (please print) Case management provider name and TPI number

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Provider phone number Provider fax number Provider e-mail

Note --Requests that don't support eligibility will be denied.
--Requests that have another provider involved in the past 2 months will be denied.
--Prior authorization is a condition of reimbursement for all services provided after September 1, 2003. Prior authorization is not a guarantee of payment.

TDH Central Office Use Only		
Received via: ☐ FAX ☐ MAIL		Date received by TDH:
Reviewed by:		Date:
Authorization number for dates of service prior to 10-16-2003:		
Comprehensive visits (9100x):	Face-to-face follow-up visits (9101X):	Telephone follow-up visits (9102X):
Date authorization effective:	Date Authorization expires: **October 16, 2003**	
Authorization number for dates of service after 10-16-2003:		
Comprehensive visits (G9012 U2 +U5):	Face-to-face follow-up visits (G9012 TS + U5)	Telephone follow-up visits (G9012 TS):
Date authorization effective: **October 16, 2003**	Date Authorization expires:	
If denied, reason for denial ☐ Required documentation not received ☐ Medicaid not in effect ☐ No need identified ☐ Documentation on request does not support client meets eligibility as defined in rule ☐ Another provider is involved. Services must be coordinated with family and		
Date request returned to provider	Staff	